MEDICAL PROCEEDINGS

MEDIESE BYDRAES

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H. A. Shapiro, B.A., Ph.D., M.B., Ch.B., F.R.S.S.Af.

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REDAKSIONEEL · EDITORIAL

DOKTERS EN DIE WET

INTEKENAARS OP 'MEDIESE BYDRAES' NOU OUTOMATIES VERSEKER VIR £10,000

Die toenemende mate waarin geneeshere in regsgedinge in ons howe verwikkel raak, is 'n saak wat groot sorg baar. Dit is 'n verskynsel wat nie eie aan Suid-Afrika is nie. Dit skyn asof dit deel uitmaak van 'n proses wat 'n kenmerk geword het van onlangse ontwikkelinge in baie ander lande, veral die Verenigde State en die Verenigde Koninkryk. In die Verenigde State van Amerika is die posisie trouens so akuut dat aktiewe stappe gedoen word om dokters te onderrig in die beste maniere om hierdie gevare van die mediese praktyk te vermy.*

Dit is egter nie alleen op die gebied van siviele litigasie dat lede van die professie aan aansienlike gevare blootgestel is nie. Dit is verontrustend om op te merk hoe maklik 'n geneesheer voor 'n strafhof gedaag kan word

* 'n Paar van hierdie probleme word baie duidelik toegelig in die spesiale medies-regs-rolprente wat deur die Wm. S. Merrell Company onder toesig van die Amerikaanse Vereniging van Advokate en die Amerikaanse Mediese Vereniging gemaak is. Hierdie rolprente is vertoon op vergaderings van die Suid-Afrikaanse Medies-Regs-vereniging en die eerste Suid-Afrikaanse Medies-Regs-kongres wat in 1958 in Johannesburg gehou is.

Twee nuwe byvoegsels tot die reeks word vertoon op die tweede Suid-Afrikaanse Medies-Regs-kongres wat in Julie vandeesjaar in Durban gehou word. (Die Organiserende Ere-sekretaris is: Prof. I. Gordon, Dekaan van die Fakulteit van Geneeskunde, Mediese Skool, Umbiloweg, Durban).

DOCTORS AND THE LAW

SUBSCRIBERS TO 'MEDICAL PROCEEDINGS' NOW AUTOMATICALLY INSURED FOR £10,000

The increasing extent to which doctors become involved in actions in our courts is a matter of grave concern. The phenomenon is not peculiar to South Africa. It appears to be part of a process which is a feature of recent developments in many other countries, particularly the U.S.A. and the U.K. The position has, in fact, become so acute in the U.S.A. that active steps have been taken to educate doctors in ways of avoiding the hazards of medical practice.*

It is, however, not only in the sphere of civil litigation that members of the profession find themselves substantially at risk. It is disturbing to observe how easily a doctor may find himself brought before a criminal court on a charge arising from an incident occurring in

* Some of the problems have been very clearly illustrated in specially prepared medico-legal films made under the supervision of the American Bar Association and the American Medical Association by the Wm. S. Merrell Company. These films have been exhibited at meetings of the South African Medico-Legal Society and the First South African Medico-Legal Congress held in Johannesburg in 1958.

Two new additions to the series will be screened at the Second South African Medico-Legal Congress to be held in Durban in July this year (Honorary Organizing Secretary: Prof. I. Gordon, Dean of the Faculty of Medicine, Medical School, Umbilo Road, Durban).

op 'n aanklag voortspruitende uit 'n insident wat in die loop van die wettige nakoming van sy praktyk plaasgevind het. Dit bring noodwendig *onvermydelike en hoë* regskoste vir die praktisyn mee, selfs wanneer hy gevindikeer word.

Een van die maniere waarop 'n mediese praktisyn hom teen hierdie gevare kan beskerm, is deur versekering—'n betreklik duur onderneming in hierdie dae wanneer die koste van regsverdediging so hoog is.

Ons het derhalwe 'n ooreenkoms met die Eagle Star Insurance Co. Ltd. aangegaan ingevolge waarvan mediese praktisyns of interns wat op *Mediese Bydraes* inteken outomaties beskerm word. Die beskerming bestaan uit 'n onderneming deur die versekeringsmaatskappy om regskoste, opgeloop deur 'n intekenaar met die goedkeuring van die maatskappy, te betaal tot 'n maksimum-bedrag van £10,000 ten opsigte van 'n eis wat onder die volgende 3 kategorieë ontstaan:

1. In verband met die regsbywoning van enige lykskouing met die doel om die intekenaar se belange te beskerm;
2. In verband met enige Dissiplinêre Ondersoek voor die Suid-Afrikaanse Geneeskundige en Tandheelkundige Raad voortspruitende uit die gedrag van sodanige intekenaar;
3. Ter verdediging van enige strafregtelike vervolging van sodanige intekenaar ten opsigte van 'n insident wat gedurende die wettige nakoming van sy praktyk voorgekom het.

Hierdie beskerming tree in werking onmiddellik nadat die uitgewers die intekenaar se tjek, of 'n berig dat hy graag intekenaar wil word, ontvang het en is geldig vir die res van die kalenderjaar.

Hierdie versekering dek die intekenaar ten opsigte van die verskillende soorte ondersoeke wat ons hierbo genoem het en wat voortspruit uit 'n insident wat op enige tydstip plaasvind nadat die uitgewers die intekenaar se intekengeld of sy instruksies om hom as intekenaar vir 1960 op te neem, ontvang het. Selfs indien sodanige ondersoek voor Desember 1962 ingestel word, is hierdie polis nog van nut vir die intekenaar.

Uit die aard van hierdie besondere soort versekering kan dit alleen aan individuele intekenaars gebied word. 'n Vennootskap kan nie vir hierdie doel 'n intekenaar word nie.

Mediese praktisyns en interns in die volgende gebiede word gedek:

Die Unie van Suid-Afrika, die Federasie van Rhodesië en Njassaland, Suidwes-Afrika en die Britse Protektorate Basoetoland, Betsjoeanaland en Swaziland.

Die verskillende voorwaardes wat op hierdie gratis versekering betrekking het, word op bladsy 87 van hierdie uitgawe uiteengesit. By intekenaars word daar aangedring om hulle sorgvuldig deur te lees.

In besonder wil ons die aandag vestig op die voorwaarde wat eis dat intekenaars onmiddellik verslag moet doen oor enige insident wat aanleiding tot 'n ondersoek kan gee.

the lawful conduct of his practice. This necessarily involves the practitioner in *unavoidable and heavy* legal costs, even if he is vindicated.

One way in which a medical practitioner may protect himself against these risks is by insurance—a relatively expensive matter in these days when the cost of legal defence is so high.

We have therefore entered into an arrangement with the Eagle Star Insurance Co. Ltd. to protect automatically those medical practitioners or interns who are subscribers to *Medical Proceedings*. The protection comprises an undertaking by the insurance company to pay the legal costs incurred with the approval of the Company by a subscriber, up to a maximum sum of £10,000 in respect of any claim arising in the following 3 categories:

1. In relation to legal attendances safeguarding the subscriber's interests at any Inquest;
2. In relation to any Disciplinary Enquiry before the South African Medical and Dental Council in connexion with the conduct of such subscriber;
3. In defending any criminal prosecution of such subscriber, in respect of an incident arising during the lawful conduct of his practice.

This protection becomes effective immediately the publishers receive the subscriber's cheque or an intimation that he wishes to be enrolled as a subscriber and operates for the balance of the calendar year.

This insurance will cover the subscriber in respect of the various types of inquiry we have referred to and which may arise from an incident occurring at any time after the publishers have received his subscription or his instructions to enrol him as a subscriber for 1960. Even if such an inquiry is instituted before December 1962, this policy will avail the subscriber.

From the nature of this insurance the protection can be offered only to individual subscribers. A partnership cannot become a subscriber for this purpose.

Medical practitioners and interns are covered in the following territories:

The Union of South Africa, The Federation of Rhodesia and Nyasaland, South West Africa and the British Protectorates of Basutoland, Bechuanaland and Swaziland.

The various conditions governing this free insurance are set out in this issue at p. 87. Subscribers are urged to read them carefully.

We wish, however, particularly to draw attention to the condition which requires subscribers to report immediately any incident which may give rise to an investigation.

DETAILS OF INSURANCE FOR SUBSCRIBERS TO MEDICAL PROCEEDINGS

The Eagle Star Insurance Company Limited has agreed, subject to the terms and conditions outlined here, to pay the legal costs incurred by a Subscriber to *Medical Proceedings* with the approval of the Company.

1. In relation to legal attendances safeguarding the Subscriber's interests at any Inquest;

2. In relation to any Disciplinary Enquiry before the South African Medical and Dental Council in connexion with the conduct of such Subscriber;

3. In defending any criminal prosecution of such Subscriber—

On the further condition that such prosecution or Disciplinary Enquiry shall be in respect of a charge of assault or culpable homicide, or shall be a Disciplinary Enquiry relating to an act or omission on the part of such Subscriber himself;

And provided further that the nature of the Inquest shall be such that the Company, in its absolute discretion, considers that the evidence to be adduced thereat may be such as to render a Subscriber in jeopardy of a criminal charge as aforesaid;

And provided further that the maximum liability of the Company to the Insured shall be the sum of £10,000 (ten thousand pounds) in respect of any single claim.

DEFINITIONS

'*Subscriber*' shall mean a Subscriber to *Medical Proceedings* registered as such in the books of the Publishers and who is a *medical practitioner or intern registered in the Territory*, and whose name has been declared to the Company by the publishers.

'*Territory*' shall mean 'the Union of South Africa, the Federation of Rhodesia and Nyasaland, South West Africa and the British Protectorates of Basutoland, Bechuanaland and Swaziland'.

EXCEPTIONS

1. The Company shall only be liable under this Policy if the assault (or in the event of a charge of culpable homicide being based upon an assault, such assault) is alleged to constitute an assault solely on the ground that the Subscriber has failed before embarking on recognized medical treatment of the person alleged to have been assaulted, to obtain the proper consent of such person or his representative to such treatment.

2. The Company shall only be liable in the case of a charge of culpable homicide in relation to the death of a patient or a Disciplinary Enquiry before the Medical Council, if such charge or Enquiry is based purely on the negligent act or omission in the course of the administration by the Subscriber himself of recognized medical treatment of such patient.

3. The Company shall in no case be liable under this Policy if in relation to any action complained of the Subscriber shall have violated any statute or statutory regulation or Ordinance having the force of law.

4. The Company shall not be liable in respect of any incident occurring at a time when the Subscriber is in any degree whatsoever under the influence of drugs or intoxicating liquor.

5. The Company shall in no case be liable in respect of any Subscriber who has at any time been prosecuted on a criminal charge or ordered to appear before the South African Medical and Dental Council (otherwise than in respect of the incident for which indemnity in respect of costs is sought), unless the Company has specifically in writing otherwise agreed.

6. The Company shall in no case be liable unless the incident for which indemnity in respect of costs is sought shall occur during the period of this Policy and when the person involved is already a Subscriber as herein defined, and unless the proceedings in respect of which the costs are incurred, shall have been initiated within a period of two (2) years from the renewal date (or in the case of this Policy having been renewed, from the renewal date immediately succeeding the date of the incident giving rise to such proceedings).

7. The Company shall only be liable under this Policy if the incident giving rise to the proceedings shall occur in the course of the lawful and normal practice of the Subscriber and within the Territory.

CONDITIONS

1. Notice of any incident likely to give rise to a claim under this Policy shall be given in writing to the Company immediately it comes to the knowledge of the Subscriber concerned, and any letter, summons or process shall be notified or forwarded to the Company imme-

diately on receipt by the Subscriber, and the Subscriber shall furthermore advise the Company in writing immediately the Subscriber shall have knowledge of any impending prosecution, Inquest or Enquiry in connexion with any incident in relation to which there may be a liability under this Policy *provided further* that the Subscriber shall give all reasonable assistance to the Company in securing information, evidence and the attendance of witnesses.

2. The Company reserves the right to require that the Subscriber be represented by Attorneys and/or Counsel to be nominated by the Company, and in the event of the Company electing to make any such nomination and the Subscriber declining to accept the Attorneys and/or Counsel so nominated, the Company shall be under no further liability hereunder in relation to such Subscriber.

3. If at the time of any incident which may give rise to a claim under this Policy there be any other subsisting insurance covering the Subscriber concerned, this Company shall only be liable for legal costs as herein defined in excess of the amount covered by such subsisting insurance.

4. The Company shall have the right to cancel cover in respect of any insured Subscriber by giving thirty (30) days' notice in writing to the publishers. Upon any such cancellation the Company shall be under no further liability to such Subscriber save in respect of any incident which has already occurred as at the date of such cancellation.

All the terms and conditions of this Policy shall, notwithstanding any cancellation, continue to apply in respect of any incident which has so occurred.

5. Nothing in this Policy contained shall give any rights against the Company to any person other than the publishers of *Medical Proceedings*.

6. In the event of the Company intimating to the publishers that it will decline liability in respect of any incident which has given or may give rise to a claim under this Policy, then in the event of legal proceedings not having been instituted by the publishers against the Company within three (3) months after the date of such intimation by the Company to the publisher, the Company shall be under no further liability in respect of any costs which may be incurred in relation to any proceeding relating to or arising out of such incident.

SOUTH AFRICA'S SCIENTIFIC FUTURE*

S. F. OOSTHUIZEN, D.Sc., F.R.C.P., M.D., F.F.R.
Pretoria

May I start by thanking you very sincerely for the great honour bestowed upon me in inviting me to open this magnificent factory to-day. It is a great day in my life because I have been placed in the position of taking part in an historic event which must inevitably have favourable repercussions over the vast African continent in the interests not only of industry and science, but also of the public.

We have until recently been wholly dependent on overseas endeavour in many basic and purely research fields, particularly in the area of pharmacology. But in discharging our great debt to the rest of the medical and scientific world, we in South Africa have taken full advantage of the opportunity so generously offered to our profession overseas. We have produced in the Union a high level of professional skill in the medical and pharmaceutical professions. The result is that we need have no fear about holding our own in the practice of our respective professions.

Whereas formerly we may not have had a great deal to offer to overseas graduates, the picture here has altered materially during recent years. The standard of the practice of medicine and pharmacy in this country is high, and will bear favourable comparison with most other countries. It is also known that a high percentage of our registered persons hold internationally recognized higher qualifications, at least partly as a result of the sanctions imposed by our system of registration of specialities. In addition, this country can offer facilities for study and research in certain specialized fields which are unequalled anywhere else; particularly in the field of environmental medicine. The point I am endeavouring to make is that to-day we have something to offer in return for what has been offered to us in the past.

* Professor Oosthuizen's address delivered on the occasion of the opening of the new Parke Davis Laboratories at Isando on Wednesday, 27 January 1960.

Our standards of professional practice are high and yet conservative and, although we are young, professionally speaking, the exponents of our clinical arts and sciences can hold their own anywhere in the world.

We see this in the pioneering work done in South Africa in the use of radio-isotopes; in Halliday's brilliant solution of the problem of carrying isotopes in the wing-tips of planes; in the development of open-heart surgery (a field in which we no longer take second place); in the decompression apparatus for making labour short and painless—a unique South African contribution; in the frog test for pregnancy—the quickest and the most accurate of the biological tests available to us and which has stood the test of trial for over a quarter of a century; in the study of heart disease, its causes and its prevention. Here our medical scientists have taken a leading role and have put us in a position to make a very special contribution to the understanding of a disease which is the major concern of the whole world; in the field of etiology of malignant disease and nutritional disorders we have made very special contributions, particularly those based on comparative studies of our white and non-white populations.

The importance of unsaturated fatty acids in suppressing cholesterol levels in the blood constitutes fundamental research carried out within our own borders. Our multi-racial society provides a natural laboratory unequalled anywhere in the world for putting to the test the theories about the causes of disease and for developing effective methods of treatment.

Parallel with these great medical advances have gone the remarkable developments in the pharmaceutical profession whose members are starting to catch up on their medical confreres. Potchefstroom is becoming a new centre for pharmaceutical training. This is important on the academic side, which is the fountain from which all else flows.

On the industrial and manufacturing side, we see an equally remarkable spate of activity. All these factors combine to create a situation in which we, as a country and as a nation, are emerging as more and more self-sustaining, although we are still a long way from complete independence; but this is the pattern that unfolds for us and this clearly is our destiny.

Logically, these advances highlight our role on the African continent which is rousing itself and taking a leading part in world affairs. South Africa could clearly become the spearhead of professional advancement and provide education, training, skills and products to serve the whole of this vast continent.

It is against this background that we must view the Parke Davis achievement of which we see the outward and visible signs before us to-day.

Standards with which manufacturers must comply are rigorous and match the standards set in the U.K. and the U.S.A. Our Therapeutic Substances Regulations clearly show the high demands that are made to comply with standards of potency and stability; this protects us from being a dumping ground for inferior products.

It is important, however, to appreciate that in the development of new products there are often no standards except those which are laid down with integrity and in the interests of public safety by the pharmaceutical industry itself. This tradition is embodied in the magnificent project which has been developed by Parke Davis and which officially sees the first light to-day.

It is therefore not surprising to learn that this undertaking will absorb something like one million dollars or, to put it in our own more homely currency, some three quarters of a million rands or £350,000. This gives us some inkling of the magnitude of this new South African venture.

What we see as we look around us is the result of 2 years' planning to house what is a new industry and which is an integral part of our own South African economy.

In these laboratories our own South African raw materials as well as those we need from the rest of the world, will be processed. Synthetic manufacture of an antibiotic can now proceed on a scale which will supply our own needs and those of Africa south of the equator. In this type of development we see a new colossus (but a benign one) astride the continent of Africa, caring for the health and welfare of the emergent peoples. We may start off by importing that vital ingredient which the Americans have so appropriately called the 'know-how'; but we are in a position to-day to develop this with our own scientific manpower, thus expanding and enhancing the intrinsic value of the achievements of South African scientists.

Why has Isando been picked as the location for important pharmaceutical developments? I cannot give you all the answers, but it is clear even to me, as a layman in these matters, that the site is strategically located as the commercial and manufacturing centre for the

greater part of South Africa and as the springboard for the rest of the continent.

The high standards of manufacturing which the industry imposes on itself (and which are generally higher than the minimum requirements which the public authority lays down) require the siting of plant in a comparatively dust-free atmosphere. This, I am given to understand, Isando provides.

It is therefore clear that every care is taken to marry the many different and diverse needs of this undertaking to maintain the highest standards demanded by our legislation.

In the Parke Davis Laboratories we can now confidently expect that generations of South African scientists will be trained on the spot to create with other similar organizations a reservoir of scientific skill devoted to the welfare of the community—by providing the doctor with the tools which have conquered some of the greatest obstacles to the development and civilization of the continent. Malaria is under control (and as you all know, Parke Davis has made a very special contribution in this field); new developments in the control of amoebiasis are on the way. Indeed, South Africa shares with only one other country, viz. Brazil, the task of developing research in this special area.

Out of this great and splendid activity must come increasingly more basic research, capable of being tackled within the borders of our own country. With this ambitious objective in mind, the pharmaceutical industry would do well to ponder the wisdom of placing more of its fundamental investigation in the clinical and pharmaceutical fields in the Union.

This Parke Davis project is an expression of the conviction and the confidence which the industry has in the capacity and the potential of South African scientific manpower and in the stability of the country itself.

Increasingly, we find that we have here scientists who can be trained (if necessary overseas in the first place, where this is justified) and who can undertake research and clinical investigation at a cost infinitely less than is possible in many of the more advanced countries.

The pharmaceutical industry itself depends for its continued existence on active basic research in the constant exploration of the secrets of nature for new, safe and effective remedies which will increasingly become the precision instruments in the practice of modern medicine.

It is only by this kind of investment in brains as well as in bricks, that we can tap our own as yet unknown potential in this field.

There may well be many secrets which may be locked up in our own flora and other indigenous material. These constitute a great challenge to purely pharmacological research in our own land.

The buildings you see around you are a symbol as well as the very real proof of a constructive effort in this direction.

It is a great pity that in South Africa private enterprise has not contributed more to scientific research and that most of the funds used in our national laboratories and universities have come from the State. It is time that the public realizes that it is profitable to invest in brains and the support of research, because high quality research is one of the prime ingredients in the training of high quality manpower. If private enterprise and the State support research they will benefit directly from better trained manpower and they will benefit ultimately from the store of knowledge they have helped to advance.

Science is the one common language understood the world over and which does not recognize national frontiers. It is dedicated to the discovery of truth and to scrutinizing every new finding and hypothesis without fear or prejudice. In science, new beliefs and principles win out over earlier ones because they have behind them the irresistible force of logic and consistency. By exchanging scientific viewpoints and working on common scientific problems, men of all nations may be drawn closer together. The endless frontiers of science can provide rich opportunities for men to seek a common understanding of the natural forces which all men must obey and which govern the world in which all men must live together.

The fact should not be overlooked that intellectual contact on the international level is an enriching experience, not only to the receiver, but also to the giver. And if the contact were between men trained in the disciplines of medicine, obviously each would have something relating to these disciplines to teach the other, but the enrichment for both would go beyond these disciplines, into other intellectual and cultural spheres. The phenomenon of insularity on the intellectual and scientific level is always an incongruous one in an adult society, more especially so in the age in which we live and where advances in the means of communication, both intellectual and physical, have shrunk the geographical frontiers of our planet so considerably.

Ten slotte wil ek graag bevestig dat Suid-Afrika dankbaar is vir die vertroue wat Parke

The new Parke, Davis laboratories at Isando, Transvaal.

Davis in hierdie land gestel het deur so 'n grootse onderneming hier op te bou, 'n onderneming wat nie alleen duisende ponde kapitaal hierheen getrek het nie maar werksmoontlikhede vir talle van persone hier verskaf het en wat verder sal bydra dat Suid-Afrika kan voortbou op die grondslag van Westerse beskawing wat as aansporing kan dien om leiding in die groot Afrikaanse vasteland te kan behou in belang van almal. Suid-Afrika sal u ook nie in die steek laat nie en sal toesien dat u nooit teleurgestel sal wees omdat u in Suid-Afrika vertroue gehad het nie.

To sum up, this meritorious venture of Parke Davis will set a high example for others to follow, it will bring capital into the country and show to the world the confidence which a great company has in South Africa; it will bring relief to numerous persons suffering from diverse diseases, and will provide a place for scientists to work in an attempt to find new methods of dealing with such illnesses.

It is because of all these evidences of wise planning for the scientific development of this country that I have great pleasure in opening this factory.

TRAUMATIC DIAPHRAGMATIC HERNIA

HELEN SENDER, M.B., B.CH. D.P.H. (RAND.), D.M.R.D. (R.C.P. & S., ENG.)
Department of Radiology, Johannesburg General Hospital, Johannesburg

A high index of suspicion on the part of the surgeon is the most important factor in diagnosing ruptured diaphragm. Clinical manifestation may vary from no symptoms to life-endangering problems immediately after the injury. The presenting symptom of massive haematemesis is, however, unusual, and has been discussed previously by Marsden,[1] who attributes the haematemesis to the pinching of imprisoned stomach vessels at the site of the trauma to the diaphragm.

Several factors conspire to prevent prompt and firm healing of the diaphragm.[2] It is believed that after an opening has been made

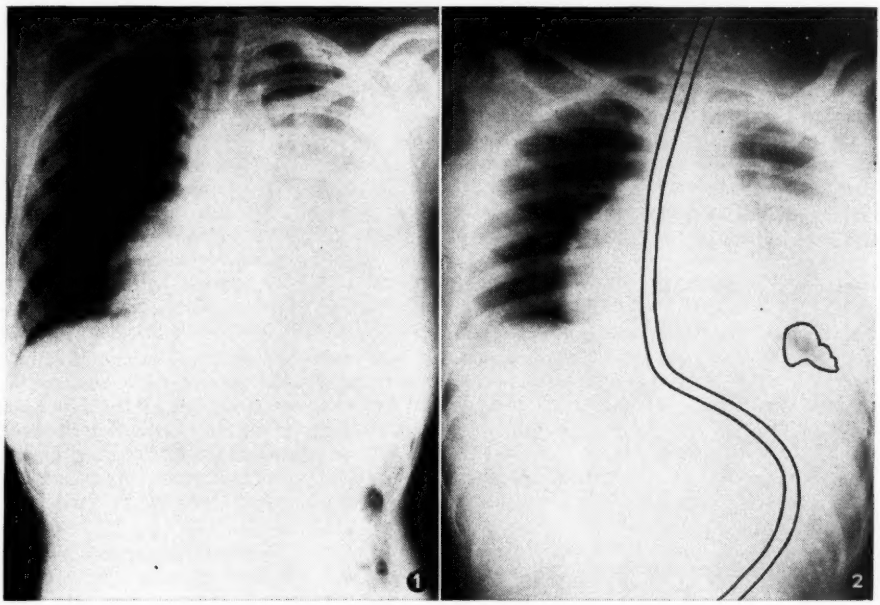

Fig. 1. Admission radiograph showing a massive left pleural effusion with displacement of the heart and the mediastinum to the right.

Fig. 2. After massive haematemesis. The stomach tube is shown *in situ*. A gas shadow in the left paracardiac region is noted.

in the diaphragm, the negative pressure in the thorax causes ascent of the intra-abdominal organs through the new orifice. In general it may be said that penetrating wounds cause smaller openings than does blunt trauma. Because the opening may be small, and because the omentum exceeds all other viscera in its propensity to protrude through the dehiscence, and because the protrusion initially may be minimal, such hernia may defy early detection even when suspected clinically. X-ray examination at this stage may show normal motility and outline of the diaphragm. Later, during periods of increased intra-abdominal pressure, abdominal organs may herniate with traumatic effects.

CASE HISTORY

An adult Bantu female aged 21 years was admitted with a stab wound in the left subcostal margin. The Casualty Officer had stated that probing showed the wound to be non-penetrating, and a few stitches were inserted. A left hydropneumothorax was present with mediastinal shift to the right. There was generalized abdominal tenderness, but no guarding or rigidity.

On the 7th hospital day the patient vomited a small amount of blood. On the 9th hospital day a sudden haematemesis of about 2 pints of blood occurred, followed by melaena, with a fall in blood pressure to 90/50 mm. Hg, and a pulse rate of 136 per minute.

At operation there was a small penetrating hole in the diaphragm through which the stomach had herniated. Two perforations of the fundus were present at the site of herniation, with actively bleeding gastric vessels.

X-RAY DIAGNOSIS

1. The admission radiograph (Fig. 1) showed a large left pleural effusion with a shift of the heart and the mediastinum to the right.

2. Radiological examination after the massive haematemesis:

(*a*) With stomach tube *in situ,* the chest radiograph showed the stomach tube lying in the stomach, which was obviously well below the diaphragm (Fig. 2).

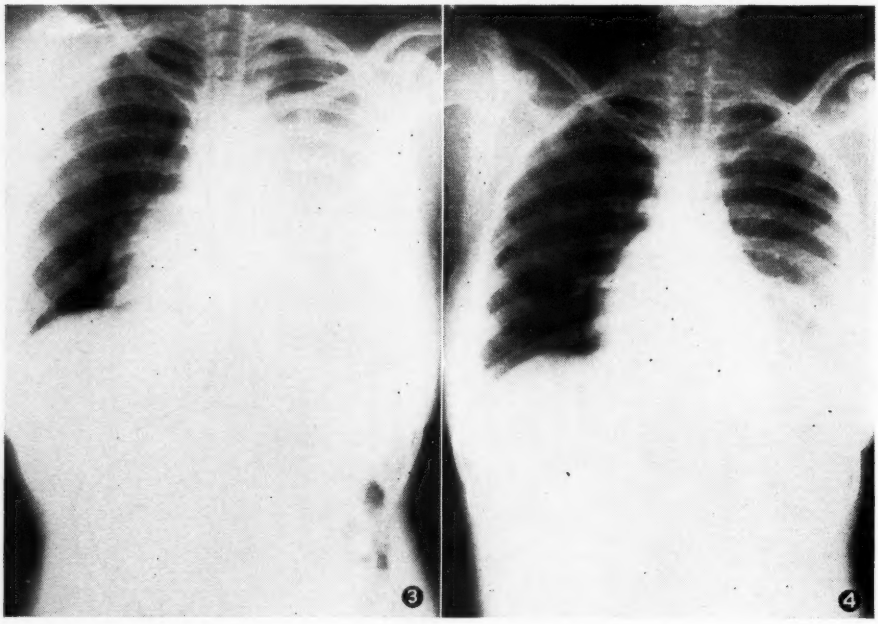

Fig. 3. Post-operative radiograph showing a stomach air bubble well below diaphragm, and disappearance of paracardiac air shadow.

Fig. 4. Follow-up radiograph showing residual small left pleural effusion and loculated hydropneumothorax. The stomach bubble again is seen well below the diaphragm.

(*b*) An extraneous gas shadow was now noted in the left cardiophrenic angle, not present on the admission radiograph. The left pleural effusion persisted unchanged.

(*c*) Screening of the diaphragm was not attempted on account of the poor condition of the patient.

Kerley[3] has described the appearance of the affected leaf of the diaphragm in cases of traumatic herniation where remarkable intermittent twitching movements, occurring at intervals of from 1 to 2 minutes, were observed. Alternatively, there may be a failure to visualize the affected leaf of the diaphragm. Kerley states that this is probably caused by the eccentric contraction on either side of the tear. The presence of blood clot may also play a part in concealing the dome.

POST OPERATIVE X-RAY EXAMINATION

The left leaf of the diaphragm was now clearly visible, and the paracardiac air shadow could no longer be seen. The stomach air bubble was now visualized well below the diaphragm (Fig. 3).

Progress radiography showed gradual absorption of the left pleural effusion with the development posteriorly of a loculated hydropneumothorax (Fig. 4). A barium meal showed normal features in the oesophagus, with no evidence of herniation either in the Trendelenburg position or after straining.

SUMMARY

A case of traumatic diaphragmatic herniation of the fundus of the stomach is presented, where the presenting symptom was one of massive haematemesis.

I wish to thank Dr. J. Kaye head of the Radiological Department at the Johannesburg General Hospital for permission to reproduce the radiographs and Mr. P. Keen under whose care the patient was admitted at the Non-European General Hospital.

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PERPHENAZINE POISONING: A CASE REPORT

A. J. CILLIERS, M.B., CH.B., D.A. (R.C.P. & S.)
Edenvale Hospital, Johannesburg

Perphenazine (Trilafon) is widely used to-day for its powerful anti-emetic properties. It is at least 5 times more potent in this respect, weight for weight, than earlier phenothiazine derivatives. Its sedative effect is of value in the treatment of psychoneuroses predominantly characterized by anxiety, tension and agitation, in certain psychotic disorders and for the control of hiccough.[1]

In contrast to reserpine and other rauwolfia derivatives which release 5-hydroxytryptamine (serotonin) from the brain, the intestinal tract and the platelets,[2] the potent phenothiazines which have central effects similar to reserpine, do not release serotonin but appear to block the action of catechol amines on the effector systems.[3]

The manufacturers warn that certain side effects may occur, predominant among which are neurological signs indicating extrapyramidal involvement. There are several case reports of these features having been observed at low or moderate dosage;[4, 5] but there are also cases on a very high therapeutic dosage who showed no such effects.[6-8] As yet, however, there is no reported case, as far as can be traced, of accidental or suicidal gross overdosage. For this reason the following case report is published.

CASE REPORT

The patient, a slightly built woman of European descent, aged 23 years, was assaulted by her husband on 25 March 1959. Her private practitioner found that she was complaining of abdominal pain and was in a highly nervous and excitable state. There was no sign of any injury at all. He prescribed A.P. Codeine tablets—2 to be taken when required for the relief of pain and Trilafon 4 mg., 1 to be taken twice daily. Her pharmacist later confirmed that he had issued to her 24 tablets containing acetylsalicylic acid 4 gr., phenacetin 4 gr. and codeine $\frac{1}{8}$ gr. each, and 36 tablets containing 4 mg. of perphenazine each.

She did not, however, take any tablets until 8.00 p.m. on the next day (26 March 1959)

when she consumed simultaneously and with suicidal intent all the tablets issued to her. She thus consumed a total dose of perphenazine 144 mg., acetylsalicylic acid 96 gr., phenacetin 96 gr., and codeine 3 gr. She could not remember much of what happened after that, except that she vomited at about 1.00 p.m. on the next day (27 March 1959).

At 4.30 p.m. the same day she was brought by a friend to the Casualty Department and was at that time unable to give any history. Her jaw was intermittently tightly clenched, but at other times she could open it widely. She had one opisthotonic spasm but no tremor was observed. She was able to say a few words but appeared very drowsy and apathetic. The facies was masklike. She co-operated however, when she received a stomach washout with a wide-bore tube. A moderate amount of partly digested meat and vegetables were seen in the washings but there was no sign of any tablets.

That evening she complained that her neck was stiff; she had pain and cramps in the jaw and she was unable to move her tongue. She also experienced subjective difficulty in breathing. Her pulse rate was 80 per minute, her respiratory rate 20 per minute and her tendon reflexes were normal. There were no positive features.

28 March 1959 at 9.00 a.m. she answered questions normally but she still appeared to be withdrawn and apathetic. There was some spasm of the neck muscles, a marked fine tremor of the hands, but otherwise nothing abnormal was observed. This was at the time atributed to an anxiety state; phenobarbitone ½ gr. tablet twice daily and hydroxyzine hydrochloride (Atarax) one tablet 25 mg. twice daily were prescribed.

At 10.50 a.m. the patient was seen in a typical oculogyric crisis. The eyes were wide open and staring, with tremor of the eyelids and a masklike facies. The eyeballs were rolling and came to rest deviated upwards and to the left. The jaw was open to its maximal extent and the head bent forward, both rigidly fixed with spasm of the neck muscles. Her tongue was protruded and blue, and sputum was drooling out of the corner of her mouth, the whole presenting an unforgettable picture of advanced classical Parkinsonism. There was now marked tremor of the upper limbs of the Parkinsonian type, while the elbows were held at right angles and exhibited 'lead pipe' rigidity.

Oral Atarax was discontinued and she was given sodium phenobarbitone 3 gr. intramuscularly and in between spasms Benzhexol or Trihexyphenidyl Hydrochloride (Artane) 2 mg. by mouth. The Artane was given twice more that day, making a total dosage of 6 mg. on 28 March 1959. The next day 6 mg. were given in divided doses, followed by 4 mg. on 30 March 1959; on 31 March 1959 one dose of 2 mg. was given. The drug was then discontinued. She continued to receive phenobarbitone, ½ gr. tablet, thrice daily.

The seizures described gradually decreased in frequency, duration and severity over the next 4 hours until the afternoon of 28 March 1959, after which they no longer occurred. The further course was uneventful with no neurological sequelae. She was seen by a neurologist on 2 April 1959 who reported that he could find no evidence of extrapyramidal tract involvement. She had apparently recovered completely from all toxic effects of the drugs taken. She was discharged on 2 April 1959 with a diagnosis of an anxiety state with hysterical features and was advised to continue with psychotherapy.

Unfortunately, due to the fact that the whole episode occurred over the Easter week-end, it was not possible to perform laboratory investigations.

DISCUSSION

As this is a case of mixed poisoning with perphenazine, acetylsalicylic acid, phenacetin and codeine, the clinical picture of perphenazine poisoning may have been to some extent modified or obscured. It resembled, very closely however, the case reported by Montgomery and Sutherland[5] in which 3 doses of perphenazine of 4 mg. each at 6-hourly intervals lead to a similar oculogyric crisis. Shaw *et al.*[4] report an extrapyramidal seizure following a single dose of perphenazine 8 mg.

In contrast, Preisig and Landman[6] reported (amongst others) a series of 9 cases receiving from 48 to 64 mg. daily with no side effects whatever. Interestingly enough, these were the cases in their series which failed to show any clinical response to the drug, resulting in progressive increments to the total dosage mentioned. There therefore appears to be a marked variation in the individual reaction to perphenazine.

Graff and Gentry[9] report the case of a woman who after taking singly 3 tablets of Trilafon Repitabs 8 mg. over a period of 25½ hours, developed a fine tremor of the jaw. She treated herself with two Empirin Compound tablets containing acetylsalicylic acid, phenacetin and caffeine. Soon after this she developed

marked generalized tremors which eventually gave way to prolonged generalized clonic convulsions. It appears probable that in this case the constituents of Empirin Compound tablets either had no effect or else aggravated the basic picture of perphenazine toxicity.

From a review of the literature[4-7, 10] concerning extrapyramidal signs following perphenazine and related phenothiazine derivatives, a characteristic picture emerges which is identical with various syndromes observed in Parkinson's disease.

The muscles of the face and neck appear to be most constantly affected. Symptoms frequently appear and then fade away only to return again later. These include:

1. Muscle tremors, rigidity and spasm:
   (*a*) Mandibular tics.
   (*b*) Protrusion of the tongue.
   (*c*) Oculogyric spasms.
   (*d*) Speech, swallowing and breathing difficulties.
   (*e*) Tonic contractions and myoclonic twitches.
   (*f*) Hyperextension of neck and trunk.
   (*g*) Peri-oral spasms.
2. Salivation.
3. Extreme restlessness and inability to keep still, described by Kinnier Wilson in post-encephalitic patients and in those with idiopathic Parkinson's disease as akathisia.

Treatment. Various sedatives have been used with good results, viz. pentobarbital sodium (Nembutal),[4] phenobarbitone,[4, 9] pethidine[5] and morphine.[7] The manufacturers of Trilafon recommended Benztropine Methanesulfonate (Cogentin) as the anti-Parkinsonian drug of choice and this was used to good effect in a case[4] of oculogyric crisis induced by a closely related drug prochlorperazine (Compazine, Stemetil).

Benztropine Methanesulphonate not being available, this case was treated with the anti-Parkinsonian drug Benzhexol or Hexyphenidyl Hydrochloride (Artane) given orally in a dosage of 6 mg. daily and tapered off gradually. This, in combination with phenobarbitone, appeared to give at least as good a result as any of the other drugs mentioned.

SUMMARY

A case of poisoning with suicidal intent with perphenazine (144 mg.) acetylsalicylic acid (96 gr.) phenacetin (96 gr.) and codeine (3 gr.) which was treated with Hexyphenidyl Hydrochloride and phenobarbitone is described.

The literature concerning the extrapyramidal toxic effects of phenothiazine derivatives is reviewed and it is concluded that there is a marked variation in individual susceptibility to side effects.

It is noted that side effects disappear spontaneously after a varying period following the withdrawal of the drug. This can be accelerated by the use of barbiturates and/or anti-Parkinsonian drugs.

There is no record of a death or of permanent neurological damage reported following an overdose of perphenazine.

My thanks are due to Dr. J. D. Prestwich, Superintendent of Edenvale Hospital, and to Dr. G. Lange, Head of the Medical Department for permission to submit this case report for publication. I wish also to thank Dr. J. Meyer and Dr. M. E. L. Tonkin for their invaluable advice and assistance.

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NOTES AND NEWS : BERIGTE

Dr. Max L. Bloom, M.B., B.Ch. (Rand), D.Obst., R.C.O.G., M.R.C.O.G., formerly Tutorial Assistant Obstetrician and Gynaecologist, University of the Witwatersrand Medical School and General Hospital, Johannesburg, has joined Dr. S. Joel Cohen and Dr. M. Cecil Michelow in practice as a Specialist Obstetrician and Gynaecologist at 208 Medical Centre, Jeppe Street, Johannesburg, and 106 Medical Centre, Krugersdorp.

Telephones:—*Rooms*: 23-7124 and 23-5555; *Residence*: 40-1746 (does not appear in the current telephone directory).

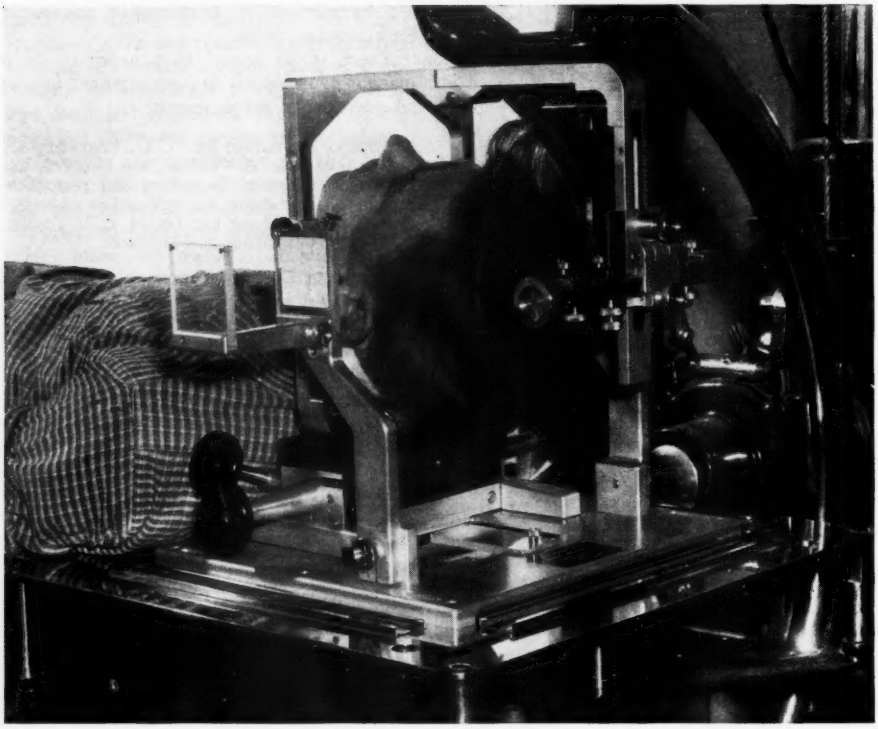
Dr. Max L. Bloom, M.B., B.Ch. (Rand), D.Obst., R.C.O.G., M.R.C.O.G., voorheen Doserende Assistent Verloskundige en Ginekoloog, Mediese Skool, Universiteit van die Witwatersrand en Algemene Hospitaal, Johannesburg, wens sy kollegas mee te deel dat hy nou met Dr S. Joel Cohen en Dr. M. Cecil Michelow in vennootskap as Verloskundige en Ginekoloog te Medical Centre 208, Johannesburg, en Medical Centre 106, Krugersdorp, praktiseer.

Telefone:—*Kamers*: 23-7124 en 23-555; *Woning*: 40-1746 (hierdie nommer verskyn nie in die jongste telefoongids nie).

THE PNEUMOTAXIC X-RAY GUIDE

A review of the measurements used in some 80 cases of Parkinson's disease suggests as reported previously (Bertrand, 1958; Bertrand, Martinez, Poirier and Gauthier, 1958) that in most individuals the lesion must be centred 15 mm. from the midline, 10 mm. below and 8 to 10 mm. behind the centre the foramen of Monro. This agrees with the results obtained by Guiot (1958), Guiot, Rougerie, Sachs and Hertzog (1958).

Accurate localization is desirable if one is to avoid changes in behaviour which may follow large lesions within the major hemisphere and, particularly, bilateral lesions, as well as damage to surrounding structures such as the cortical-spinal and optic tracts.



With the pneumotaxic guide the point to be studied is brought in line with the central ray of a standard X-ray tube. Thus, in the lateral projection, distances can be measured on a superimposed grid directly on the X-ray film with a minimal amount of magnification. In the antero-posterior projection, the needle electrode and the leucotome are introduced parallel to the sagittal plane at a measured distance from the midline.

The pneumotaxic guide can be used for any approach to problems of localization over the convexity.

Visual, face and leg responses can be obtained from front to back along the postero-internal border of the globus pallidus. The optimum site for lesions lies just above and in front of the point for motor face stimulation. In most individuals, this point falls at 15 mm. from the midline, 10 mm. below and 8 to 10 mm. behind the centre of the foramen of Monro. Within these limits the section is centred slightly more posteriorly for tremor than for rigidity. A section so situated will produce marked hypotonia and good to excellent results. Destruction slightly more postero-inferiorly may cause transitory choreiform movements. To be effective in choreathetosis, the lesion must be carried further back and involve the cortico-spinal tract. The transitory drop in prothrombin time which follows these lesions, can be easily prevented by the administration of vitamin K. In the more advanced cases, bronchopneumonia and urinary retention must be watched for during the period of post-operative drowsiness. During that time patients tolerate fairly large doses of amphetamine sulphate, but they would seem to be hypersensitive to chlorpromazine.

The cortical atrophy evidenced by pneumoencephalography in the senile form of the disease is entirely different from the large ventricular dilatation of younger individuals with so-called post-encephlitic parkinsonism.

Lesions 12 mm. in diameter seem to produce durable results, but the minimal effective lesion is still undetermined, a point which would favour wider use of the procedure.

THE 1960 EASTER STAMP CAMPAIGN

The Easter Stamp Fund for Cripples prevents at least 80% of permanent crippledom caused by crippling diseases, birth defects, arthritis and polio.

The sale of Easter stamps replenishes the Easter Stamp Fund for Cripples.

* * *

Maybaker (S.A.) (Pty) Ltd. announce that their Transvaal Depot is now at 43 Juta Street, Johannesburg.

The telephone numbers have also been changed and will be 835-5425/6 from 29 February 1960. The Post Office Box number, however, will remain unaltered, i.e. P.O. Box 3926, Johannesburg.

The object of moving to larger premises is in order to provide a better service for customers in the Transvaal.

MEDICAL CONFERENCE OF THE STUDENTS' MEDICAL COUNCIL

UNIVERSITY OF THE WITWATERSRAND

The Seventeenth Annual Conference will be held at the Medical School, Johannesburg, from 16–20 May, on *The Kidney*.

The Conference will be addressed by the Union's leading authorities on the subject.

* * *

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

MEDICAL GRADUATES ASSOCIATION

A course of *Seminars on Behaviour Disorders in Childhood* will again be held during 1960. Members interested in taking part should contact Dr. J. Katz at the Child Guidance Clinic, Johannesburg.

Ward rounds at Coronation Hospital are held every Friday afternoon at 2 p.m. Visitors to the hospital should telephone the hospital on the day of the round to confirm if it is taking place. (*Telephone*: 27-3331.)

At the first Alumni Dinner held to honour the first graduates of the University of the Witwatersrand Medical School a Bursary Fund was inaugurated. The graduates of subsequent years have made donations at their respective Alumni Dinners and this year for the first time a Bursary Award will be made.

PREPARATIONS AND APPLIANCES

DIHYDERGOT TABLETS

Composition: *Dihydergot* tablets contain 1 mg. of the methanesulphonate of dihydroergotamine, an ergot alkaloid obtained by the partial hydrogenation of ergotamine.

Dihydergot is a relatively non-toxic drug with few side effects even when given in high doses. Central toxic disturbances do not occur; nausea or vomiting are very infrequent accompaniments of administration.

Mode of Action: *Dihydergot* possesses a strong sympathicolytic action with a negligible effect on blood pressure or on uterine activity except at term. It may safely be given by mouth and in moderate dosage during pregnancy.

Dihydergot elicits a strong vasotonic effect on distended extracranial arteries, thus relieving the stretching of pain-sensitive structures. This action is limited only to those vessels which are pathologically distended; the peripheral circulation is not affected. *Dihydergot* is therefore extensively used in attacks of migraine and in other headaches of vascular origin.

Indications for Dihydergot Tablets and Ampoules: Migraine attacks and migraine prevention. Tension headaches, histaminic cephalalgia or Horton's syndrome. Headaches following lumbar puncture and spinal anaesthesia. Postoperative retention of urine. Hypotension, neurocirculatory asthenia.

Dosage. Migraine Phophylaxis: 1–2 tablets 3 times daily.

Migraine Attacks: 2–3 tablets repeated after half hour if necessary. Severe cases require *Dihydergot* injections or *Cafergot* orally or rectally.

Distributors: Alex. Lipworth Limited, P.O. Box 4461, Johannesburg. Alex. Lipworth (Rhodesia) Limited, P.O. Box 1769, Salisbury.

THE SIMON-WEIDNER CHOLEDOCHOSCOPE FOR THE POST-CHOLECYSTECTOMY SYNDROME

A new operating endoscope for the bile ducts has been developed by Richard Wolf G.m.b.H. for use in cholescystic surgery in order to deal with the post-cholycystectomy syndrome. The instrument is known as a choledochoscope.

This instrument works on the same principles as a cystoscope. The ducts can be easily inspected and simultaneous irrigation as well as instrumental intervention under optical control can be carried out. It is now possible to inspect the ducts downwards to Oddi's sphincter and even beyond, also towards the liver and the main branches of the hepatic ducts. With this method, hidden concretions and calculi can be detected and which, in the past, could not be removed.

Special forceps designed for this endoscope can extract these concretions. Biopsy specimens can also be taken. Electro-cautery splitting of Oddi's sphincter with a special ring electrode can be performed within a matter of seconds.

The use of this instrument offers advantages inasmuch as satisfactory results are obtained, when for technical reasons radiocholangioscopy or cholangiography is not possible.

In conjunction with these aforementioned procedures, however, the choledochoscope offers the advantage of a clear anatomical picture, together with the possibility of intervention which was not possible with conventional surgical methods.

The usefulness of this instrument has been described by Dr. Simon-Weidner in a recent article in Medical Proceedings, **6**, 77.

Enquiries from: Frederick C. Marcus, P.O. Box 3039, Cape Town. *Telephone*: 41-2831 and 2-3231.

MARPLAN

A NEW MONOAMINE OXIDASE REGULATOR

Roche Products (Pty.) Limited announce the synthesis of a new monoamine oxidase regulator with a double action:

1. Mood elevation, psychostimulation, e.g. an antidepressant;

2. Increased coronary blood flow, freedom from anginal pain, decreased peripheral resistance with slightly lowered blood pressure (outstanding amongst its cardiovascular effects) and decreased oxygen requirements of the myocardium.

Chemistry: *Marplan* is: 1-benzyl-2-(5-methyl-3-isoxazolylcarbonyl) hydrazine, a monoamine oxidase regulator or inhibitor.

Pharmacology: Monoamine oxidase (MAO) is an enzyme widely distributed in the body. It oxidatively deaminates amines to pharmacologically inactive acidic derivatives.

Marplan (by inhibiting MAO) increases the tissue levels of:

1. Serotonin (5-hydroxytryptamine);
2. Norepinephrine (noradrenaline);
3. Epinephrine (adrenaline).

Indications:—(*a*) *Psychiatry*: In the treatment of the depressive phase of the manic-depressive psychosis; in endogenous depressions and generally in affective disorders with depression as a symptom; in involutional and senile psychosis; in schizophrenia where the predominant symptom is depression.

It can be used in conjuction with EST and has in some cases replaced EST therapy.

(*b*) *Cardiology*: In the treatment of mild hypertension and in coronary artery diseases as a dilator, e.g. in angina of effort.

(*c*) *The Double Effect* of *Marplan* makes it an almost ideal drug for the depressed patient with acute or chronic coronary artery diseases.

Toxicity: Although *Marplan* is very potent, no hepatotoxic or haematotoxic effect has been demonstrated. Side effects are good indicators of individual sensitivity.

Side Effects: Irritability, orthostatic hypotension, insomnia, dizziness, constipation, dryness of the mouth.

Contra-Indications: Acute excitatory states and psychomotor hyperactivity; jaundice; renal failure.

Dosage: This is variable: From an initial dose of 30 mg. daily to a maintenance of approximately 10 mg. daily. (The preparation has accumulative effects and dosage must be controlled).

Samples and literature from: Roche Products (Pty.) Limited, P.O. Box 6158, Johannesburg.

REVIEWS OF BOOKS

PROBLEMS OF THE AGEING

Mental Health Problems of Ageing and the Aged: *Sixth Report of the Expert Committee on Mental Health*. World Health Organization: Technical Report Series. 1959, No. 171; 51 pages. 3s. 6d. Pretoria: Van Schaik's Bookstore (Pty.) Ltd., P.O. Box 724.

'Peu de gens savent être vieux' (La Rochefoucauld): to-day the opportunity is open to a greater number than ever before, but successful adaptation to ageing is still beyond the skill of many. Over considerable areas of the world is has become a commonplace to expect as a right a long and productive working life followed by a secure retirement period; but the increased life span is of such comparatively recent date that the populations concerned have not learned either to take full advantage of it or to deal with the problems it raises. When, however, it is accompanied by insecurity, loneliness and illness, as it still too often is, the benefit of living to an advanced age, both for the individual and for the community, is much reduced. Relief for some of the more obvious evils has long been available in a greater or lesser degree; governments and private undertakings have introduced schemes for social security, and considerable interest in geriatrics has developed, but the need for promoting mental health among the aged is only now being recognized. The sixth *Report* of the WHO Expert Committee on Mental Health is devoted to this topic.

As is well known, during the nineteenth century the population of most European countries underwent a rapid expansion, while the steep decline in the birth rate which set in at the beginning of the present century in many of the industrialized countries of Western Europe, allied with the great advances in medical treatment, resulted in a sharp rise in the relative proportion of the aged. The health and welfare services are already strained by increasing demands for care of old persons, necessary on the grounds of their physical or psychological incapacity to carry on normal life unaided.

The Committee's *Report* analyses first the extent and sources of the mental health problems of ageing and the aged exemplifying them as they are reflected in the hospitalization and suicide figures for the aged in certain countries. A view which has often been put forward is that in some parts of the world the economic changes of recent years have produced a withering of family affection and a general disintegration of the family group. Sociological investigations in industrialized areas, however, have indicated that this factor has been exaggerated, and that the great majority of old people are in regular contact with their children, other relatives and friends. Nevertheless, there remains a small core of lonely old people, and a tendency towards an imbalance of age-groups in certain newly-developed communities. Poverty, lack of occupation after retirement, factors of a psychological or physical nature in the past life of the individual, and mental or physical disease

itself, may all contribute to the difficulties experienced in mental adjustment to ageing.

The Committee elaborates each of these aspects in the main body of its *Report*, which contains proposals for the protection and promotion of mental health in old age, the classification and prognosis of mental disease in old age, and the organization of geriatric mental health services, as well as a brief review of specific measures for treatment and rehabilitation (e.g. psychotherapy, electro-convulsive treatment, psychotropic agents). The need for close collaboration between the different specialities concerned with the old patient, and the valuable part that should be played by the family doctor, are emphasized and recommendations are made on training and research.

In the opinion of the Committee, the key to the problem lies in the organization of mental health services for the aged within a comprehensive geriatric service, which has a guidance centre as its core. These services should comprise facilities both for the preservation of mental health and for the treatment of mental disorder. The Committee stresses the principle of looking after the old as far as possible in their own homes (with domiciliary assistance when required), and of re-integrating them into the community as soon as possible after treatment away from home. The services would need to be so co-ordinated —as indeed they are in some parts of the world— that the old person would quickly get whatever attention he required, and should be flexible enough to ensure continuity of care. In rapidly developing countries, where the proportion of the aged in the population (and so their mental health problems) is likely to increase considerably in the near future, it will become necessary to devote attention to the careful planning of integrated services for the aged.

By these means, the Committee hopes greater advantage may be taken of the longer period of productivity and the increasing numbers of old people, whose experience can be a valuable contribution to the community.

TREATMENT OF TUBERCULOSIS

Treatment of Lung Cavities and Endobronchial Tuberculosis: With Special Reference to Treatment in Malaya. By Beryl E. Barsby, M.D., M.R.C.P. (1959. Pp. 142 + Index. With 46 Figs. 20s.). Edinburgh: E. & S. Livingstone Ltd.

This study is based on work done by the author in Malaya where the patients were either of Chinese, Malayan or Indian origin. These 3 main races were found to respond differently to tuberculous infection both in their parenchymal and their endobronchial manifestations.

Some 1,126 endobronchial investigations were carried out. It was found that the grade of endobronchitis, as determined histologically, bore no relationship to the radiological type of the disease.

The Malayans contracted the most acute form of pulmonary tuberculosis and showed the highest incidence of associated endobronchitis. Reported variations in the incidence of endobronchitis in previous writings have been as great as from 4% to 95%. These variations have been attributed to many causes, but the author concludes from her study that the incidence is dependent upon the stage of the disease originally encountered.

The possibility of associated endobronchitis should always be considered where symptoms and signs cannot be explained by the radiological picture. An unexplained positive sputum or haemoptysis may be mentioned as illustrative examples in this connexion.

In the treatment of tuberculous endobronchitis, the author found that the most effective plan was daily treatment with streptomycin sulphate 1 gm. in combination with INH 100 mg. twice daily. This daily therapy was continued until 2 consecutive X-rays at 3-monthly intervals showed no further improvement and the active endobronchitis had healed.

It is interesting that although a very low INH dosage was employed compared with the 600–1000 mg. daily often given in this country, Dr. Busby still found a high incidence of the 'burning foot syndrome' and peripheral neuritis.

In the treatment of lung cavities, postural retention started at the same time as the drug therapy was found to be very effective in bringing about cavity closure.

SURGERY OF THE FOOT

Surgery of the Foot. By Henri L. du Vries, M.D. (1959. Pp. 469 + Index. With 403 Figs. 106s. 3d.). St. Louis: C. V. Mosby Company.

The general appearance of this book, the quality of the paper, and the impression gained from idly paging through its contents, are all excellent. There are numerous figures, well reproduced, illustrating the text.

It may be that the author's interest and past experience affect the selection of subject matter, for as Edward L. Compere points out in the introduction, 'the author had his early training in chiropody and only subsequently became a doctor of medicine'. Subjects that so often tend to be overlooked, such as disorders of the skin itself, including corns and callosities, and disorders of the sesamoids, are fully dealt with, the author being guided largely by his own experience, but still with reference to the opinions of others.

Further interesting and detailed sections on *Sprains* and *Athletic Injuries of the Foot, Diseases and Deformities of the Toenails,* and *The Foot in Diabetes,* are similarly rich in detail and contain much valuable information. In these chapters the book is of value not only to orthopaedic surgeons but also to general practitioners, who are particularly interested in the causation and treatment of these troublesome conditions.

On the other hand, when it is realized that matters like *Flat Feet* or *Club Feet* are dealt with in a few scant pages, then one hesitates to recommend the book, except to those who seek only the special detail required. The opening chapters, too, embracing *Examination and Diagnosis, Operative Principles and Requirements,* and especially *The Structure and Function of the Foot,* seem superfluous for those who have a knowledge of these subjects, and inadequate for those whose knowledge is scanty. In any case, it is relatively unimportant whether one interprets 'the purpose of the foot as a transmitting mechanism to a supporting structure rather than as being a supporting structure in itself'.

For selected reading the book will doubtless serve a purpose.

MINOR HAND INJURIES

The Care of Minor Hand Injuries. By Adrian E. Flatt, M.A., M.D., F.R.C.S. (1959. Pp. 260 + Index. With 109 Figs. 80s. 9d.). St. Louis: C. V. Mosby Company.

In this modern world, with its extension of mechanization and mechanical transport, hand injuries are all too prevalent.

On analysis of the number of cases treated under the Workmen's Compensation Act, the number of industrial accidents in this country, in spite of every possible precaution that can be devised, is ever on the increase. Minor hand injuries form a large proportion of these accidents, and because proper and adequate treatment is not administered, the results are crippling, and the loss of man-hours is enormous.

Many hospitals are increasingly aware of this important factor, and are establishing hand clinics to which all such hand injuries are being sent. On the other hand, far too many cases are inexpertly handled due to a lack of knowledge or interest, as the injuries are considered minor. Minor hand injuries are major hazards for the workman.

Minor Hand Injuries by Adrian E. Flatt is an excellent book for every general practitioner and specialist who has to deal with such injuries. The author began work in the emergency clinic of a London hospital, and his concern for the bad results led him to a more detailed study of this subject. The result: less crippling, disability, and less loss of man-hours.

The book is divided into 2 sections: general principles of care; and care of specific injuries.

The book is extremely well illustrated, and the delightful style and the clarity of expression in which it is written, make for easy reading. It is impossible to single out any chapter. This book is a *must* for everyone who undertakes to treat injuries of the hand.

CORRESPONDENCE

THE PHYSICIAN'S PRAYER

To the Editor: I apologize for taking up valuable space in your journal over what is, in my opinion, a storm in a teacup. However, I have received a personal public insult, and this accusation I must defend.

Dr. S. Levin (whose academic qualifications I respect profoundly) has been pleased to call my adaptation from a *Prayer in Prose* by *Anonymous* (and incidentally *not* by the late Dr. W. O. Rubidge) an impertinence and doggerel. In actual fact the impertinence rests squarely on the shoulders of the good Dr. Levin, whose information is sadly at fault.

Whether my verse is doggerel or not is a matter of opinion. It might be opportune for Dr. Levin's benefit to define doggerel: 'A form of rhyme where the language of the street, i.e. everday language or even slang is the medium used.'

The lines I have written do not rhyme and, in my opinion, even the most prejudiced critic can hardly accuse me of having used the language of the street or slang.

I feel that if Dr. Levin is a gentleman (and I do not for a moment doubt this), in the light of subsequent events, he will give me an absolute apology.

On reading the original *Prayer* (*South African Medical Journal*, 10 July 1954, p. 598, *author not stated*) and obituary notice of the late Dr. Rubidge, I was so moved by the lofty prose and the sterling remarks passed by Dr. P. H. Marks concerning our late colleague, that I wrote to the late Doctor's secretary and to Dr. Marks for permission to convert the *Prayer* into blank verse. I received assurance that the author was *not known*.

I duly sent in my adaptation to the *South African Medical Journal* with a full explanation and acknowledgment of its source (14 August 1954, p. 700). I would not presume to write an original prayer. The lines, however, received favourable comment (*South African Medical Journal*, 11 September 1954, p. 796). When I was persuaded to hand in this verse for re-publication by Dr. Wilson, medical consultant at Baragwanath, I displayed at the same time all the relevant journal 'cuttings' and information which I have outlined here. It was for the committee concerned to decide whether I could sign my name to the verse. Apparently they were satisfied both with its standard and its *bona fide* nature.

I am not here concerned with the merits or demerits of the verse. Dr. S. Levin has jumped to erroneous conclusions, and, in so doing, has let his 'prejudice breed false beliefs'—an unhealthy state of mind, indeed.

Arnold Rieck, M.B., Ch.B., D.A.

Krugersdorp Hospital,
Krugersdorp, Transvaal.

COMMISSION OF INQUIRY: HIGH COST OF MEDICAL SERVICES AND MEDICINES

To the Editor: Your Editorial in your issue of 13 February 1960 on *The Commission of Inquiry into the High Cost of Medical Services and Medicines* draws attention to several important points in respect of the difficult matter to which the Commission is addressing itself.

I would like to add a few supplementary points which may be of interest to the Commission.

1. We should bear in mind, in evaluating the present cost of medical services (and of drugs, for that matter) the marked reduction in the purchasing power of our currency during the last decade or so.

2. The 'incredible relief on the strain of nursing and medical care generally', to which you refer, means equally an incredible relief in human suffering —something which cannot be evaluated in terms of money.

3. In an analysis of the items which make up the cost of modern drugs, it is important to appreciate the considerable expenditure invested by the pharmaceutical industry in basic research. Indeed, it would not be unreasonable to estimate the investment in pharmaceutical research, from which South Africa benefits directly, at a figure of about £500,000 yearly. The industry would be quite correct in regarding this as an item which must be taken into account in any analysis of the cost structure of modern chemotherapeutic agents.

GALEN.